General

Guideline Title

Management of early rheumatoid arthritis. A national clinical guideline.

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of early rheumatoid arthritis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2011 Feb. 27 p. (SIGN publication; no. 123). [110 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Management of early rheumatoid arthritis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2000. 44 p. (SIGN publication; no. 48). [202 references]

Recommendations

Major Recommendations

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the original guideline document.

The grades of recommendations (A–D) and levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Diagnosis of Early Rheumatoid Arthritis

B - Anti-cyclic citrullinated peptide 2 (CCP2) antibody may be used as part of the assessment of a patient suspected of an early inflammatory polyarthritis such as RA.

Principles of Management

Early Treatment

B - Early initiation of treatment with disease modifying anti-rheumatic drugs (DMARDs) is recommended to control the symptoms and signs of rheumatoid arthritis (RA) as well as limiting radiological damage.

Treat-to-Target Strategies

B - Patients with moderate to severe disease activity should:

- Be assessed for disease activity using a standardized scoring system such as DAS/ DAS28
- Be reviewed monthly until remission or a low disease activity score is achieved
- Receive treatment with DMARDs, adjusted with the aim of achieving remission or a low DAS/DAS28 score

Analgesics and Non-Steroidal Anti-Inflammatory Drugs

Summary of Strategies to Minimize the Risk of Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)

- B - The lowest NSAID dose compatible with symptom relief should be prescribed.
- B - NSAID dose should be reduced and if possible withdrawn when a good response to DMARDs is achieved.

B - Gastroprotection should be introduced for patients with RA at risk of NSAID-associated gastroduodenal ulcers.

Disease Modifying Drugs

Systemic Corticosteroids – Oral and Parental

A - Low-dose oral corticosteroids can be used in combination with DMARD therapy for short term relief of signs and symptoms, and in the medium to long term to minimize radiological damage.

Disease Modifying Anti-Rheumatic Drugs

Efficacy and Toxicity

A - Methotrexate and sulfasalazine are the DMARDs of choice due to their more favourable efficacy and toxicity profiles.

B - DMARD therapy should be sustained in patients with early RA to control the signs and symptoms of disease.

Treatment Strategies

A - A combination DMARD strategy, rather than sequential monotherapy, should be considered in patients with an inadequate response to initial DMARD therapy.

The Role of the Multidisciplinary Team

Occupational Therapy

Activities of Daily Living

C - Skilled occupational therapy advice should be available to those experiencing limitations in function.

Physiotherapy

Exercise Therapy

B - Patients should be encouraged to undertake simple dynamic exercises.

Splinting

C: Resting and working splints can be used to provide pain relief.

Definitions:

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1–: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies; high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2–: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies, e.g., case reports, case series

4: Expert opinion

Grades of Recommendation

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A: At least one meta-analysis, systematic review, or RCT rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Early rheumatoid arthritis (RA)

Notes:

> Early RA is defined in this guideline as disease duration of ≤5 years from onset of symptoms.
> The guideline does not address the treatment of comorbidities (e.g., anaemia, osteoporosis), complications of drug therapy and their management, or treatment of extra-articular disease (e.g., vasculitis, ocular complications, amyloid).

Guideline Category

Diagnosis

Evaluation

Management

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Nutrition

Physical Medicine and Rehabilitation

Podiatry

Rheumatology

Intended Users

Dietitians

Nurses

Occupational Therapists

Pharmacists

Physical Therapists

Physicians

Podiatrists

Guideline Objective(s)

To present evidence-based recommendations for the diagnosis of early rheumatoid arthritis, its pharmacological treatment including symptom relief and disease modification, and the role of the multidisciplinary team in improving care of patients with rheumatoid arthritis

Target Population

Adults with rheumatoid arthritis

Interventions and Practices Considered

Diagnosis/Evaluation

1. Measurement of anti-cyclic citrullinated peptide (anti-CCP) antibodies
2. Assessment of disease activity, using an activity scoring system (DAS/DAS28)

Management/Treatment

1. Patient education
2. Multidisciplinary team management
3. Early initiation of and sustained treatment with disease modifying anti-rheumatic drugs (DMARDs) (e.g., methotrexate, sulfasalazine)
4. Treat-to-target strategy (DAS/DAS28 assessments, monthly monitoring until target is reached, adjustment of DMARDs)
5. Minimization of non-steroidal anti-inflammatory drug (NSAIDs) side effects by prescribing low dose and reducing dose when possible
6. Low-dose oral corticosteroids with DMARDs
7. Combinations DMARDs for poor response to initial treatment
8. Provision of occupational therapy advice, as needed

9. Encouragement to follow simple dynamic exercise
10. Use of resting and working splints

Note: Use of the tumour necrosis factor alpha (TNF-α) inhibitors for the treatment of severe, active and progressive rheumatoid arthritis in adults not previously treated with methotrexate or other DMARDs was considered but not recommended.

Major Outcomes Considered

- Sensitivity and specificity of diagnostic testing
- Change in disease activity score (DAS/DAS28)
- Time to improvement
- Remission rate
- Relapse rate
- Overall quality of life
- Adverse drug effects

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Literature Review

The evidence base for this guideline was synthesised in accordance with Scottish Intercollegiate Guidelines Network (SIGN) methodology. A systematic review of the literature was carried out using an explicit search strategy devised by a SIGN Information Officer in collaboration with members of the guideline development group.

For the 2011 update the Cochrane Library, Medline and Embase were used to identify studies relating to the key questions listed in Annex 1 of the original guideline document. For the initial update searches the date range covered was 2003–2009. Additional searches were carried out on key questions 2a and 8 following peer review with a date range of 2003-May 2010. The search results were supplemented by material identified by individual members of the guideline development group.

Patient Search

At the start of the guideline development process, a SIGN Information Officer conducted a literature search for qualitative and quantitative studies that addressed patient issues of relevance to the management of early rheumatoid arthritis. Databases searched include Medline, Embase, CINAHL and PsycINFO, and the results were summarised and presented to the guideline development group.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1–: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies; high quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal

2–: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies, e.g. case reports, case series

4: Expert opinion

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. The result of this assessment will affect the level of evidence allocated to the paper, which will in turn influence the grade of recommendation that it supports.

The methodological assessment is based on a number of key questions that focus on those aspects of the study design that research has shown to have a significant influence on the validity of the results reported and conclusions drawn. These key questions differ between study types, and a range of checklists is used to bring a degree of consistency to the assessment process. Scottish Intercollegiate Guidelines Network (SIGN) has based its assessments on the MERGE (Method for Evaluating Research and Guideline Evidence) checklists developed by the New South Wales Department of Health, which have been subjected to wide consultation and evaluation. These checklists were subjected to detailed evaluation and adaptation to meet SIGN's requirements for a balance between methodological rigor and practicality of use.

The assessment process inevitably involves a degree of subjective judgment. The extent to which a study meets a particular criterion (e.g., an acceptable level of loss to follow up) and, more importantly, the likely impact of this on the reported results from the study will depend on the clinical context. To minimize any potential bias resulting from this, each study must be evaluated independently by at least two group members. Any differences in assessment should then be discussed by the full group. Where differences cannot be resolved, an independent reviewer or an experienced member of SIGN Executive staff will arbitrate to reach an agreed quality assessment.

Evidence Tables

Evidence tables are compiled by SIGN Executive staff based on the quality assessments of individual studies provided by guideline development group members. The tables summarise all the validated studies identified from the systematic literature review relating to each key question. They are presented in a standard format to make it easier to compare results across studies, and will present separately the evidence for each outcome measure used in the published studies. These evidence tables form an essential part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

Additional details can be found in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]), available from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Synthesizing the Evidence

Guideline recommendations are graded to differentiate between those based on strong evidence and those based on weak evidence. This judgment is made on the basis of an (objective) assessment of the design and quality of each study and a (perhaps more subjective) judgment on the consistency, clinical relevance and external validity of the whole body of evidence. The aim is to produce a recommendation that is evidence-based, but which is relevant to the way in which health care is delivered in Scotland and is therefore implementable.

It is important to emphasize that the grading does not relate to the importance of the recommendation, but to the strength of the supporting evidence and, in particular, to the predictive power of the study designs from which that data was obtained. Thus, the grading assigned to a recommendation indicates to users the likelihood that, if that recommendation is implemented, the predicted outcome will be achieved.

Considered Judgment

It is rare for the evidence to show clearly and unambiguously what course of action should be recommended for any given question. Consequently, it is not always clear to those who were not involved in the decision making process how guideline developers were able to arrive at their recommendations, given the evidence they had to base them on. In order to address this problem, the Scottish Intercollegiate Guideline Network (SIGN) has introduced the concept of considered judgment.

Under the heading of considered judgment, guideline development groups summarize their view of the total body of evidence covered by each evidence table. This summary view is expected to cover the following aspects:

- Quantity, quality, and consistency of evidence
- External validity (generalisability) of studies
- Directness of application to the target population for the guideline
- Any evidence of potential harms associated with implementation of a recommendation
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources required by the National Health Service [NHS] in Scotland to treat them in accordance with the recommendation)
- Whether, and to what extent, any equality groups may be particularly advantaged or disadvantaged by the recommendations made
- Implementability (i.e., how practical it would be for the NHS in Scotland to implement the recommendation)

The group are finally asked to summarise its view on all of these issues, both the quality of the evidence and its potential impact, before making a graded recommendation. This summary should be succinct, and taken together with its views of the level of evidence represent the first draft of the text that will appear in the guideline immediately before a graded recommendation.

Additional detail about SIGN's process for formulating guideline recommendations is provided in Section 6 of the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN Web site .

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A: At least one meta-analysis, systematic review, or randomized controlled trial (RCT) rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The national open meeting is the main consultative phase of Scottish Intercollegiate Guidelines Network (SIGN) guideline development.

Peer Review

All SIGN guidelines are reviewed in draft form by independent expert referees, who are asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline. A number of general practitioners (GPs) and other primary care practitioners also provide comments on the guideline from the primary care perspective, concentrating particularly on the clarity of the recommendations and their assessment of the usefulness of the guideline as a working tool for the primary care team. The draft is also sent to at least two lay reviewers in order to obtain comments from the patient's perspective.

It should be noted that all reviewers are invited to comment as individuals, not as representatives of any particular organization or group. Corporate interests, whether commercial, professional, or societal have an opportunity to make representations at the national meeting stage where they can send representatives to the meeting or provide comment on the draft produced for that meeting. Peer reviewers are asked to complete a declaration of interests form.

The comments received from peer reviewers and others are carefully tabulated and discussed with the Chair and with the guideline development group. Each point must be addressed and any changes to the guideline as a result noted or, if no change is made, the reasons for this recorded.

As a final quality control check prior to publication, the guideline and the summary of peer reviewers' comments are reviewed by the SIGN Editorial Group for that guideline to ensure that each point has been addressed adequately and that any risk of bias in the guideline development process as a whole has been minimised. Each member of the guideline development group is then asked formally to approve the final guideline for publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- The goal of early treatment for rheumatoid arthritis (RA) is to achieve clinical and radiological remission and reduce functional limitations and permanent joint damage.
- People living with RA can achieve good quality of life with support and skills training to manage their condition effectively.

Potential Harms

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Side effects of non-steroidal anti-inflammatory drugs (NSAIDs) are dose and duration of therapy dependent. The gastrointestinal (GI) and cardiovascular side effects are of particular concern. Other less common but equally serious side effects include renal disease and hypersensitivity (including asthma).

Gastrointestinal Side Effects

- Ulceration of the gastrointestinal (GI) tract, particularly of the stomach and duodenum, arises due to the systemic inhibition of prostaglandins. Symptoms correlate poorly with GI ulceration which can occur throughout the length of the GI tract. GI bleeding, perforation and gastric outlet obstruction are recognized complications of ulceration.
- The risk of GI bleeding is the most frequent complication of GI ulceration and occurrence differs between NSAIDs. Although the frequency of gastroduodenal ulceration is less with selective cyclo-oxygenase 2 (COX-2) inhibitors compared to non-selective NSAIDs the case for reduced GI ulcer complication rates is unproven.

Risk Factors for NSAID-Associated Gastroduodenal Ulcers

Definite Risk Factors	Possible Lifestyle Factors
Advanced age (linear increase in risk)	Cigarette smoking
History of ulcer	Alcohol consumption
Higher doses of NSAIDS	
Combination use of NSAIDS	
Concomitant use of corticosteroids	
Comorbidity	

Cardiovascular Side Effects

- An increased risk of arterial thrombotic events such as acute myocardial infarction or stroke has been noted with some selective COX-2 inhibitors and the non-selective NSAIDs, although the overall risk is small. This risk applies to all NSAID users and not just those at risk of cardiovascular events and occurrence increases with duration of treatment as well as being dose dependent. Differences are shown between NSAIDs: diclofenac (150 mg daily) and ibuprofen (2.4 g daily) are associated with an increased risk but naproxen (1 g daily) and lower doses of ibuprofen (1.2 g daily or less) are not. Data on other NSAIDs are, as yet, inconclusive.

Systemic Corticosteroid Therapy

Long-Term Side Effects

- A meta-analysis concluded that low-dose corticosteroid use in patients with RA reduces bone mineral density. A randomised controlled trial (RCT) concluded that prednisolone 10 mg once daily also increased the risk of fractures.
- Two case controlled studies show increased side effects in corticosteroid treated patients with RA, including cataracts, infections, GI bleeds, avascular necrosis and fractures (the Medicines and Healthcare Products Regulatory Agency has drawn attention to the additional risks of

chickenpox exposure in patients not previously infected).
- Increased mortality has also been reported in RA patients on corticosteroids.

Disease Modifying Anti-Rheumatic Drugs (DMARDs)

The DMARDs for use in RA include ciclosporin A, hydroxychloroquine (HCQ), leflunomide (LEF), methotrexate (MTX), intramuscular gold, penicillamine and sulfasalazine (SASP).

- Intramuscular gold has the highest toxicity and therefore increased treatment drop-out rates compared to SASP, HCQ and MTX.
- A systematic review found LEF, MTX and SASP to have comparable efficacy. MTX has the most favourable efficacy/toxicity trade-off. SASP scored close to MTX and had more adverse events initially. HCQ had a relatively low rate of toxicity.
- In two randomised placebo controlled studies relapse in symptoms and signs occurred on withdrawal of DMARDS demonstrating that sustained use is necessary.

Contraindications

Contraindications

Non-steroidal anti-inflammatory drugs (NSAIDs) and cyclo-oxygenase 2 (COX-2) inhibitors should be avoided in patients with ischaemic heart disease, cerebrovascular disease, peripheral arterial disease and moderate to severe heart failure.

Qualifying Statements

Qualifying Statements

- This guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is, however, advised that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.
- Every care is taken to ensure that this publication is correct in every detail at the time of publication. However, in the event of errors or omissions corrections will be published in the web version of this document, which is the definitive version at all times. This version can be found on the web site www.sign.ac.uk .

Prescribing of Licensed Medicines Outwith Their Marketing Authorisation

Recommendations within this guideline are based on the best clinical evidence. Some recommendations may be for medicines prescribed outwith the marketing authorisation (product licence). This is known as 'off label' use. It is not unusual for medicines to be prescribed outwith their product licence and this can be necessary for a variety of reasons.

Generally the unlicensed use of medicines becomes necessary if the clinical need cannot be met by licensed medicines; such use should be supported by appropriate evidence and experience.

Medicines may be prescribed outwith their product licence in the following circumstances:

- For an indication not specified within the marketing authorisation
- For administration via a different route
- For administration of a different dose

Prescribing medicines outside the recommendations of their marketing authorisation alters (and probably increases) the prescribers' professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines.

Any practitioner following a SIGN recommendation and prescribing a licensed medicine outwith the product licence needs to be aware that they are responsible for this decision, and in the event of adverse outcomes, may be required to justify the actions that they have taken.

Prior to prescribing, the licensing status of a medication should be checked in the current version of the British National Formulary (BNF).

Implementation of the Guideline

Description of Implementation Strategy

Implementation

Implementation of national clinical guidelines is the responsibility of each National Health Service (NHS) Board and is an essential part of clinical governance. Mechanisms should be in place to review care provided against the guideline recommendations. The reasons for any differences should be assessed and addressed where appropriate. Local arrangements should then be made to implement the national guideline in individual hospitals, units and practices.

Implementation of this guideline will be encouraged and supported by the Scottish Intercollegiate Guidelines Network (SIGN).

Resource Implications of Key Recommendations

No recommendations are considered likely to reach the £5 million threshold which warrants full cost impact analysis.

Auditing Current Practice

A first step in implementing a clinical practice guideline is to gain an understanding of current clinical practice. Audit tools designed around guideline recommendations can assist in this process. Audit tools should be comprehensive but not time consuming to use. Successful implementation and audit of guideline recommendations requires good communication between staff and multidisciplinary team working.

The guideline development group has identified the following as key points to audit to assist with the implementation of this guideline:

- Time from GP referral to rheumatology specialist
- Number of patients with moderate to severe activity:
    - Assessed for disease activity using tools such as DAS/DAS 28
    - Reviewed on a monthly basis until remission or low disease activity score achieved
    - Treated with disease-modifying antirheumatic drugs (DMARDs), adjusted with the aim of achieving remission or a low DAS/DAS 28 score
- Time from symptom onset to introduction of DMARD therapy
- Access to multidisciplinary team

Implementation Tools

Audit Criteria/Indicators

Quick Reference Guides/Physician Guides

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of early rheumatoid arthritis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2011 Feb. 27 p. (SIGN publication; no. 123). [110 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2000 Dec (revised 2011 Feb)

Guideline Developer(s)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

Source(s) of Funding

Scottish Executive Health Department

Guideline Committee

Not stated

Composition of Group That Authored the Guideline

Guideline Development Group: Dr Rajan Madhok, Consultant Rheumatologist, Glasgow Royal Infirmary (Chair); Ms Jayne Argyle, Rheumatology Clinical Nurse Specialist, Heathfield Clinic, Ayr; Mrs Mhairi Brandon, Lead/Principal Specialist Physiotherapist in Rheumatology, Glasgow Royal Infirmary; Ms Carole Callaghan, Pharmacist, Western General Hospital, Edinburgh; Ms Angela Donaldson, Co-Director Arthritis Care Scotland, Glasgow; Professor Tracey Howe, Director, HealthQWest, Glasgow Caledonian University; Miss Jennifer Layden, Programme Manager, SIGN; Ms Jan Manson, Information Officer, SIGN; Dr Alan MacDonald, Consultant Rheumatologist, Aberdeen Royal Infirmary; Ms Joan Mackintosh, Senior Clinical Pharmacist, Raigmore Hospital, Inverness; Dr Gayle McKellar, Consultant Rheumatologist, Pinderfields General Hospital, Wakefield; Dr Duncan Porter, Senior Lecturer and Consultant Rheumatologist, Gartnavel General Hospital, Glasgow; Mr Duncan Service, Senior Information Officer, SIGN; Ms Ailsa Stein, Programme Manager, SIGN; Miss Ann Tierney, Research and Business Systems Manager, Glasgow Royal Infirmary; Dr Debbie Turner, Senior Lecturer in Podiatry, Glasgow Caledonian University

Financial Disclosures/Conflicts of Interest

All members of the guideline development group made declarations of interest and further details of these are available on request from the Scottish

Intercollegiate Guidelines Network (SIGN) Executive.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Management of early rheumatoid arthritis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2000. 44 p. (SIGN publication; no. 48). [202 references]

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Availability of Companion Documents

The following are available:

- Quick reference guide: Management of early rheumatoid arthritis. Scottish Intercollegiate Guidelines Network, 2011 Feb. 2 p. Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .
- SIGN 50: A guideline developer's handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2011 Nov. 111 p. (SIGN publication; no. 50). Electronic copies available from the SIGN Web site .
- Appraising the quality of clinical guidelines. The SIGN guide to the AGREE (Appraisal of Guidelines Research and Evaluation) guideline appraisal instrument. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001. Available from the SIGN Web site .

Section 9 of the original guideline document also contains key points to audit.

Patient Resources

None available

NGC Status

This summary was completed by ECRI on October 17, 2001. The information was verified by the guideline developer as of December 17, 2001. This NGC summary was updated by ECRI Institute on February 15, 2012. The updated information was verified by the guideline developer on March 7, 2012. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs).

Copyright Statement

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